STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005074	A. BUILDING _____ B. WING _____	C 08/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEACONESS HOSPITAL INC	600 MARY ST EVANSVILLE, IN 47747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State hospital complaint. Complaint number: IN00106530 Unsubstantiated, lack of sufficient evidence Date of survey: 08-06-12 Facility number: 005074 Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Deaconess Hospital Inc. is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 08/13/12	S 000		